hand carry the beeper while jogging. To our knowledge, this complication of jogging has not previously been reported, but we suspect it is not an uncommon occurrence in obsessive/compulsive physician-joggers who cannot part with their beepers.

Beeper bite raises problems of morals and medical ethics. Why carry a beeper at all unless telephones are handy? Is it appropriate to ask another physician to take calls for an hour or so of jogging time, every day? Since one of the reasons for jogging is to "get away from it all" for a brief time each day, is not the act of carrying a beeper inconsistent with this goal? These issues should be carefully considered by a physician involved in a regular jogging program.

E. MICHAEL LEWIECKI, MD
WILLIAM van H. MASON, MD
Presbyterian Hospital
Albuquerque, New Mexico

Family Medicine for Primary Care

TO THE EDITOR: I would like to agree with Dr. Geyman's editorial comments regarding Dr. Kurtz's January article on primary care.[1,2] Dr. Kurtz has a misunderstanding of the need for family medicine as a specialty. Primary care internal medicine or pediatrics is not an acceptable alternative to family medicine.

I have lived most of my life in the rural areas of Idaho and Wyoming, and am familiar with the rural areas of Nevada and Southwestern Montana. I have received only praise from those people who live in the rural areas for choosing family medicine as my specialty.

Why? The answer is always the same: "Because we want a family doctor!" They do not want to be shifted from an internist to a pediatrician to an obstetrician or from a child health associate to a physician's assistant or a nurse practitioner to a nurse midwife. They want centralized, continuous care for themselves and their children from a family doctor, especially one who does obstetrics.

The need for family physicians is as great as the need for other specialists. Family physicians are in demand. They are cost effective, and the new family physicians are well trained.

Primary care training already exists in the excellent specialty of family medicine. There is no need for such a subspecialty in internal medicine or pediatrics. What is needed is continued growth and cooperation among the disciplines of family medicine, internal medicine, pediatrics, surgery, and obstetrics and gynecology so that quality training is available.

JACK LAVIN, MD
Family Medicine Resident
University of Colorado Health Sciences Center
Denver

REFERENCES

1. Kurtz KJ: Training the internist for primary care: A view from Nevada (Medical Education). West J Med 1982 Jan; 136: 76-82
2. Geyman JP: Training for primary care: A family practice perspective (Medical Education: Editorial Comment). West J Med 1982 Jan; 136:83-84

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TO THE EDITOR: Dr. Kenneth Kurtz subtitles his recent article on primary care training[1] as "A View From Nevada." I wonder if he intended to represent Tonopah, Elko or even the communities of metropolitan Reno. From reading his article, it is apparent that his views emanate from a department of internal medicine at a university medical center.

Dr. Kurtz conceptualizes a model where nurse practitioners would possibly manage problems that require limited medical knowledge "in each sector of the family practice sphere," with single discipline specialists such as a primary care internist with five years of postgraduate training providing the rest. Do most people want or need a team that combines two extremes?

Dr. Kurtz indicates that "family practice physicians are caught in the intense squeeze of modern biomedicine." As a recent family practice residency graduate now in practice, I have not felt squeezed nor have I noticed this among my colleagues. The joy of entering practice after a family practice residency is the realization of being very well trained to manage the great majority of people's health problems. I wonder if Dr. Kurtz has stepped beyond the clinics of academia to experience this.

Dr. Kurtz also states that because of the breadth of family practice training, the result is "often a very broad, but necessarily superficial, knowledge of many aspects of medicine." I will readily admit a superficial knowledge of cryoglobulins, renal tubular acidosis, and Wegener's granulomatosis. However, along with an in-depth knowledge of the persons and families who are my patients, I know ambulatory diabetes, hypertension, obesity, degenerative arthritis, congestive heart failure, and so forth, as well as a good primary care internist.

It is unfortunate that so many internists and others in the academic setting do not accept

family practice training as legitimate in producing a competent physician. Because of this, medical students are given distorted myths and family practice residents are unnecessarily hassled. People everywhere seem to like having a good family doctor, and most of the towns in this country are too small to support any other type of physician. Apparently, physicians with three or more years of training in a single discipline cannot accept competence in a field with three years of training covering many disciplines. How many months or years of postgraduate training does it take to become competent in an area of medicine? Ironically, Dr. Kurtz feels that more than three years are necessary for competence with adult medical problems, while his residents in primary care internal medicine are likely to learn their gynecology and orthopedics in a few months.

Some academic internists have been very supportive of family practice and have greatly helped the discipline become established in medical education. An editorial by Perkoff eloquently describes this attitude.[2] As stated by Geyman[3] there will be several approaches to primary care in this country. Americans like variety and choices, and family physicians, pediatricians and internists all have their place on the front lines of medical practice. We should respect and help each other in meeting the public's needs, for if we do not I imagine that chiropractors and others will.

JOSEPH E. SCHERGER, MD
Dixon, California

REFERENCES

1 Kurtz KJ: Training the internist for primary care: A view from Nevada. West J Med 1982 Jan; 136:76-82

2. Perkoff GT: Family practice: Potential for a key role in medical care. Arch Intern Med 1981 Jul; 141:979-982

3. Geyman JP: Training for primary care: A family practice perspective. West J Med 1982 Jan; 136:83-84

Incidence of *Campylobacter* Enterocolitis

To THE EDITOR: I enjoyed Dr. Ginsberg's short review of gastrointestinal disease and infectious diarrhea[1] in the January issue. However, the discussion on *Campylobacter fetus* subspecies *jejuni* does not emphasize the frequency of enterocolitis due to this organism. Recent data indicate that in numerous geographic areas *Campylobacter* is as common as *Salmonella* and *Shigella* combined.[2,3] Our experience in Marin County, northern California, suggests that *Campylobacter* enteritis is far more frequent than this. Two community hospitals are finding many more times *Campylobacter* versus *Shigella* and *Salmonella*. In 1981, there were 290 stool cultures processed from a 34-physician multispecialty group. Thirty-seven were positive for *Campylobacter jejuni,* one for *Shigella* and three for *Salmonella*. The cases involving *Salmonella* and *Shigella* occurred in the summer months and there was a clear epidemiological history. The cases involving *Campylobacter* were more evenly spread throughout the year, with increased frequency from September through to December. Most stool specimens positive for *Campylobacter* contained blood or polymorphonucleocytes, or both.

Frequent occurrence of disease due to *Campylobacter* in the winter months is an important issue for community clinicians. This bacterium should be considered as the most likely cause of acute diarrhea when the stool contains blood and pus. Whether erythromycin therapy should be started before culture results are obtained (often taking two to three days) has not been studied. The natural course of *Campylobacter* enteritis does not appear to be influenced by therapy started as late as four to six days after onset of symptoms.[3] Certainly our anecdotal experience suggests prompt resolution of the often debilitating symptoms when treatment has been started before the confirmation of *Campylobacter* enterocolitis by culture.

MARTIN JOFFE, MD
Department of Pediatric Gastroenterology
Ross Valley Medical Clinic
Greenbrae, California

REFERENCES

1. Ginsberg NN: Gastrointestinal disease (Epitomes of Progress—Preventive Medicine and Public Health). West J Med 1982 Jan; 136:147

2. Drake AA, Gilchrist MJR: Diarrhea due to *Campylobacter fetus* subspecies *jejuni*. Mayo Clin Proc 1981 Jul; 54:414-423

3. Laser NS, Reller LB: *Campylobacter* enteritis. N Engl J Med 1981 Dec 10; 305(24):1444-1452